3. Espada R, Talwalker NG, Wilcox G, Kleiman NS, Verani MS. Visualization of ventricular fibroelastoma with a video-assisted thoracoscope. *Ann Thorac Surg*. 1997;63:221-3.

doi:10.1016/j.jtcvs.2007.11.064

Right atrial papillary fibroelastoma associated with atrial septal defect, persistent superior vena cava, and coronary artery disease

To the Editor:

We read with interest the article by Lauten and coworkers[1] regarding the successful resection of a right atrial papillary fibroelastoma (PF). We have additional surgical experience with this infrequent location of the neoplasm.

A 60-year-old man with a history of arterial hypertension and a transient ischemic attack underwent a transthoracic echocardiogram, which demonstrated a mass inside the right atrium (RA). Further cardiologic evaluation including transesophageal echocardiogram and complete cardiac catheterization and coronary arteriography disclosed a tumor in the RA, fenestrated atrial septal defect (ASD), persistent left superior vena cava (LSVC), and severe coronary artery disease with tight stenosis in the proximal left anterior descending coronary artery (LAD) and middle right coronary artery (RCA).The patient underwent surgery on June 6, 1998. A median sternotomy was performed. Under standard cardiopulmonary bypass, with cannulation of the aorta, both venae cavae, and the LSVC, the aorta was crossclamped. Intermittent cold blood cardioplegia was administered and the three venae cavae were snared. A right atriotomy was performed, a 2 $\times$1.5-cm gelatinous tumor attached to the muscular endocardium of the RA was completely removed, an ostium secundum type of ASD was closed with an autologous pericardial patch, and a double coronary bypass graft to the LAD and RCA was carried out. The patient had an uncomplicated surgery and recovery and was discharged home 10 days after the operation. Gross and histologic examination of the mass was typical of PF. At present, 9 years 6 months after the operation, the patient remains asymptomatic. A recent transthoracic echocardiogram showed no intracavitary masses, closure of the interatrial septum, and normal left ventricular function.

PF is an endocardial tumor that represents the second or third most common cardiac neoplasm, accounting for less than 10% of all primary benign heart tumors. It is most frequent in the left side of the heart and generally develops in the heart valves; however, other endocardial heart locations have also been described. Right PF arising from the nontricuspid valve or interatrial septum is extremely uncommon. We only found a few surgically treated patients.[1-7] To the best of our knowledge, excision of a free-wall PF in association with closure of an ASD and coronary artery bypass grafting has not been previously reported.

Cipriano Abad, MD[a]
Pilar De la Rosa, MD[b]
Department of Cardiovascular Surgery[a]
Department of Pathology[b]
Hospital Universitario
de Gran Canaria Dr Negrin
Las Palmas de Gran Canaria, Spain

References

1. Lauten A, Strauch JT, Wipperman J, Walers T. A rare type of right tumor in a 66-year-old woman. *J Thorac Cardiovasc Surg*. 2007;133:251-2.
2. Gallas MT, Reardon MJ, Reardon PR, De Felice CA, Raizner AE, Mody DR. Papillary fibroelastoma. A right atrial presentation. *Tex Heart Inst J*. 1993;20:293-5.
3. Singh H, Alam M, Schwartz D, Martin JR. Right atrial papillary elastoma: an uncommon location. *Echocardiography*. 2004;21:273-4.
4. Hindupur S, Schwabe JL. Papillary fibroelastoma of the right atrium: an atypical presentation. A case report and review of the literature. *J Cardiovasc Surg*. 2005;46:589-91.
5. Gabbieri D, Rossi G, Barutti L, Corghi L, Zaca F, Sarandria D, et al. Papillary fibroelastoma of the right atrium as an unusual source of recurrent pulmonary embolism. *J Cardiovasc Med (Hagerstown)*. 2006;7:273-8.
6. Lotto A, Earl UM, Owens A. Right mass. Thrombus, myxoma, or cardiac papillary fibroelastoma? *J Thorac Cardiovasc Surg*. 2006;132:159-60.
7. Kim RW, Jeffery ME, Smith MJ, Wilensky Rl, Woo EY, Woo YJ. Minimally invasive resection of papillary fibroelastoma in a high-risk patient. *J Cardiovasc Med (Hagerstown)*. 2007;8:639-41.

doi:10.1016/j.jtcvs.2008.01.042

The present and the future in aortic stenosis management: Are there factors that might preclude surgery?

To the Editor:

I read with great interest the article by Bertrand Marcheix and associates.[1] I congratulate them for this well-designed study, but I also wish to add some brief comments. The aim was to determine the impact of less-invasive techniques for treatment of high-risk patients with aortic valve disease by using a self-expandable aortic bioprosthesis (CoreValve Inc, Paris, France) suitable for percutaneous retrograde delivery. The mean logistic EuroSCORE was 32%. Of 10 patients undergoing successful implants, 2 died within 30 days and a third died later, for an overall 30% hospital mortality. Vascular complications were observed in 5 patients. Mean intensive care unit stay was 4.6 days and hospital stay was 15 days. The authors concluded that the technique is a viable alternative in selected high-risk patients.

With the aim of reducing surgical invasiveness, epidural anesthesia, maintaining an autonomic ventilation, has been suggested,[2] and the outcomes of 30 consecutive patients who underwent epidural awake aortic valve surgery (47% female, mean age 78.1% $\pm$ 8, 20% multivessel coronary disease, mean Logistic-EuroScore 28.3) have been presented at the European Association for Cardio-thoracic Surgery meeting in Geneva. One patient had a redo operation. Associated surgical procedures included coronary artery bypass grafting (17%), ascending aorta replacement (10%), mitral valve surgery (10%), and pulmonary vein isolation to treat atrial fibrillation. Unless emergency, no other exclusion criteria were considered. One patient died, for an operative mortality of 3%, and 2 patients died during the follow-up period (natural death). All other complications occurred rarely (stroke, no cases; bowel ischemia, no cases; prolonged mechanical ventilation, 2 cases; myocardial infarction, 1 case). Median stays in the ward and the intensive care unit were 4.5 days and 1 day, respectively. Seven patients have been transferred to the ward within 3 hours after surgery and 19 patients in 12 hours or less.

The goal of aortic valve stenosis treatment is to achieve a complete regression of symptoms while offering the lowest morbidity and mortality. The main reason that percutaneous interventions are more acceptable to the patients is the simplicity. Unfortunately, interventional cardiologists and cardiac surgeons are going to rethink the management of high-risk aortic stenosis[1,3,4] without a well-founded clinical program and forgetting the patients' and economic